LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

February 17, 2015

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/CONSULTANTS
Brad Land, *Co-Chair*	Al Ballesteros, MBA, *Co-Chair*	Traci Bivens-Davis	Jane Nachazel
Michelle Enfield	Miguel Martinez, MPH, MSW	Deborah Collins	Yeghishe Nazinyan, MS, MD
Abad Lopez	Marc McMillin	Aaron Fox	
Juan Rivera	Mario Pérez, MPH	Joseph Green	
Sabel Samone-Loreca	Monique Tula	Miki Jackson	**DHSP STAFF**
	LaShonda Spencer, MD	Juan Preciado	Sophia Rumanes, MPH
		Terry Smith	Carlos Vega-Matos, MPA
		Jason Wise	Amy Wohl, MPH, PhD
			Juhua Wu, MS

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *2/17/2015*
2) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *8/28/2012*
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *4/23/2013*
4) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *5/28/2013*
5) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *6/10/2013*
6) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *1/20/2015*
7) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *1/27/2015*
8) **Report**: Comprehensive HIV Plan Task Force Recommendations, *1/27/2015*
9) **Memorandum**: City of Long Beach Data Request, *1/29/2015*
10) **PowerPoint**: Update on the Implementation of Ambulatory Outpatient, *1/27/2015*
11) **PowerPoint**: Linkage to, Re-engagement in and Retention in HIV Medical Care Overview, *1/17/2015*

1. **CALL TO ORDER:** Mr. Land called the meeting to order at 1:02 pm.

2. **APPROVAL OF AGENDA:**
   MOTION #1: Approve the Agenda Order **(*Postponed*)**.

3. **APPROVAL OF MEETING MINUTES:**
   MOTION #2: Approve minutes from the 8/28/2012, 4/23/2013, 5/28/2013, 6/10/2013, 1/20/2015 and 1/27/2015 Planning, Priorities and Allocations (PP&A) Committee meetings, as presented **(*Postponed*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)*:** There were no comments.

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)*:** There were no comments.

6. **CO-CHAIRS' REPORT:**

- The Comprehensive HIV Planning (CHP) Task Force referred its report to the Executive Committee and has suspended meetings pending Executive's review. The Task Force discussed access, but the report does not specifically address it. Dr. Nazinyan is developing an annual surveillance document for Executive to function as the first dashboard element.
- ➲ Forward Miki Jackson's comment requesting inclusion of access in CHP Task Force report to Executive Committee.

7. CITY OF LONG BEACH SERVICE UTILZATION:

A. Review Casewatch, Surveillance and FY 15 Utilization Data Projections:

- PP&A was asked to review City of Long Beach service data at the 1/8/2015 Commission meeting
- Mr. Vega-Matos reported DHSP budgeted for six Fee For Service (FFS) Ambulatory Outpatient Medical (AOM) visits per patient per year. The average is three to four with just 500 to 600 patients countywide using six or more.
- Medical Care Coordination (MCC) is also providing medical visit savings by helping manage high acuity cases.
- There were 4,667 PLWH in the City based on surveillance data as of 12/31/2014. PLWH may seek AOM services via sources such as Covered California, Medicaid Expansion or Ryan White Program (RWP) sites located outside the City.
- In RWP YR 23, 596 unduplicated RWP-eligible patients living in the City received AOM services in a RWP-funded medical home. That number declined to 377 unduplicated RWP-eligible patients in RWP YR 24.
- DHSP has allocated $592,037 for YR 25 to pay for AOM visits for RWP-eligible patients on a FFS basis across the City's four current DHSP-funded medical homes supporting an estimated 1,794 visits. Assuming an average of four AOM visits per patient, current funding will support a minimum of 448 RWP-eligible patients across the four sites. DHSP has delegated authority to increase funding to any of the four sites should there be an increase in demand for services.
- Starting several years ago with Healthy Way LA, Medicaid Expansion and ACA implementation, DHSP has seen a steady decline in demand for AOM services for the RWP-eligible population based on contracted service providers' own data entered into Casewatch and used for billing purposes. Based on available data, DHSP does not find a lack of access.
- Ms. Jackson felt it was also important to identify an estimate of and plan services to address unmet need, i.e., PLWH who know they are HIV+, but have not entered HIV-related medical care. She noted one of the few concerns HRSA raised in its 2013 audit of the County was insufficient attention to addressing unmet need.
- Mr. Land noted the Standards and Best Practices (SBP) Committee was also reviewing best practices for patient choice.
- ➲ Request DHSP provide an out of care estimate for the City of Long Beach.

8. HIV PREVENTION AND LINKAGE TO CARE (LTC) OVERVIEW:

A. HIV Prevention Gaps/Barriers: Dr. Wohl and Ms. Rumanes provided a PowerPoint presentation, reviewed below, on HIV Prevention and Linkage to Care (LTC), Retention and Engagement. Federal funders have shifted focus to treatment as prevention and CDC estimates the percentage of PLWH out of care has declined from 18% to 14%. Consistent with the federal approach and a DHSP RAND modeling study, DHSP is focusing on LTC and retention.

B. Linkage to Care, Retention and Engagement Gaps/Barriers:

- A total 66,290 STD and HIV/AIDS cases were reported in the County in 2013 excluding STDs from the Cities of Long Beach and Pasadena. The County has the second highest jurisdiction totals in the country.
- Percentages are similar for US and County HIV Treatment Cascade diagnosis and TLC, but the County achieves better results than the US for; Retained In Care (RIC), 46% v. 37%; prescription of ART, 41% v. 33%; and virally suppressed, 34% v. 25%. PLWH receiving RWP medical care and prescribed ART exceed County averages with 83% having an undetectable VL. DHSP recently reviewed all medical providers. All met RIC benchmarks and patient VLs were reduced.
- A County grant to improve HIV planning and modeling brought to the fore strategies such as test to treat and high impact testing that are consistent with RAND modeling which stressed a focus on bringing out of care PLWH into care.
- The CDC requires LTC and engagement in all contracts. HRSA has no LTC category per se, but provides a table which identifies other service categories that can be used to fund LTC activities and which activities each category can fund.
- The County currently has 10 testing, LTC, re-engagement and retention programs. Two Navigation programs are designed to re-engage lost HIV clinic patients using both PHI locator techniques and a re-engagement intervention.
- Distinct, but linked, programs for HIV testing, LTC, engagement and MCC are needed to effectively help PLWH progress from unaware through to optimum care, e.g., surveillance data confirms HIV status to avert duplicative tests, engages those already diagnosed in LTC with appropriate navigation to ensure retention and engages HIV- people in prevention.
- The County is integrating Navigation project lessons into a larger County-Based Linkage and Retention Program (LRP) using surveillance, tired interventions and both street outreach and clinics to reach each pertinent population.

- Multiple methods can be used to identify out of care people, but should be coordinated/consolidated to ensure vulnerable populations are approached in a consistent manner by one source rather than several uncoordinated ones.
- Many out of care PLWH require only a phone call to engage. Others benefit from one Motivational Interviewing intervention session on the importance of care and staying in care to address ambivalence or minor challenges. A subset of clients with multiple barriers/challenges needs up to 10 modified ARTAS visits to fully achieve retention.
- Six-month retention rates for Navigation program clients was not particularly good at first, but has improved since implementation of MCC. Some clients also need a transitional retention component in which navigators work with the MCC team for six to nine months to ensure the patient stays in care.
- Project Engage is an additional program designed to test effectiveness of social network (Snowball sampling) and direct recruitment (flyers, word of mouth) to identify marginalized out of care PLWH, e.g., sex workers, IDUs and homeless. That population is not as likely to be identified from clinic records used by the two Navigation programs.
- Project Engage has enrolled 132 clients to date with enrollment continuing. Of those enrolled, 39% are African-American; 24%, White; 23%, Latino; 14%, other/mixed. On gender/orientation, 85% are Male; 4%, Female; 14%, Transgender; with 85%, lesbian/gay/bisexual; 15%, heterosexual. Insurance was 55%, public; 32%, none; 13%, private.
- The original program did not include an intervention piece, but assessed readiness to engage in care as pre-contemplative, contemplative or ready for care. Many clients who initially felt they were ready, in fact, needed retention assistance. The next iteration, Project Engage 2.0, will include the three-tiered intervention piece.
- Barriers were similar to those reported by Navigation clients: 41%, individual, e.g., did not know where to go, substance abuse, too sick; 29%, structural, e.g., confusing system, wait times, transportation, not eligible, or immigration status concerns; 20%, organizational, e.g., did not complete paperwork, financial issues, language barrier, disrespectful staff.
- Of 71 clients recruited via Snowball sampling, 51 (72%) were linked to care and, of 23 initially retained in care, 19 (82%) were retained. It took a mean of 27.2 days and 6.7 hours for staff to link clients to care with VLs declining with length of retention. It was particularly important to link this population to MCC due to barriers.
- Mr. Land suggested working with, e.g., LA Care to coordinate LTC, but Ms. Rumanes said many services, e.g., outreach, are unlikely to be reimbursable. Mr. Vega-Matos added DHSP can do a great deal within HRSA categories that other providers cannot. There is a different conversation with payer sources such as LA Care on standards and best practices.
- Ms. Bivens-Davis felt, as a navigator, that role was missing from the conversation though agencies normally lack them. When projects end, navigators leave and client connections are lost. Dr. Wohl agreed navigators are especially needed to reach the most marginalized. Programs are becoming more long-term for that reason. Mr. Rivera, patient advocate, said patients often need someone not part of clinic staff for short, intense hand-holding to ensure retention.
- Ms. Rumanes said Identifying out of care persons is more efficient with HIV surveillance data, but there are legal limits to sharing it and other useful County data with non-County employees. Only HIV case report data can be shared with a clinic, e.g., it can be shared that a patient is in care elsewhere, but not where. DHSP engaged in extensive discussions with County Counsel to delineate procedures within HIPPA regulations. Consequently, DHSP advocated for an internal County program since Public Health staff has access to information such as surveillance data within HIPPA guidance.
- It should be noted patient consent forms allow a provider only to share information needed for a specific service. That makes provider buy-in all the more important to prioritize activities such as follow-up calls and text messages.
- Timely LTC and continued engagement in HIV care is an ongoing problem with a variety of issues, e.g., ensuring tired interventions and utilizing multiple methods to identify out of care PLWH within legal limitations. Reaching the most vulnerable populations is labor intensive requiring provider/facility buy-in and workforce skill and training, e.g., in negotiation, LTC, engagement and retention. A large client volume is needed to ensure cost effectiveness of dedicated staff. LRP can be incorporated into existing clinical and/or CBO services with MCC, as needed, for support.

➲ DHSP staff will send Linkage to Care, Retention and Engagement PowerPoint to Commission staff for PP&A distribution.
➲ Request DHSP add data on drug usage, not just IDUs, to Linkage to Care, Retention and Engagement PowerPoint.
➲ Request DHSP provide Ryan White in care treatment cascade data by race/ethnicity, gender and age.
➲ Request DHSP collect data on PLWH disabled due to HIV as a regular part of demographic data.
➲ Add to parking lot for DHSP consideration: Evaluate high-volume emergency rooms as sites for LTC.
➲ Mr. Vega-Matos noted DHSP will provide feedback on PP&A's list of potential services to initiate or augment at the March meeting. Services which can be used for LTC, engagement and retention will be addressed.

9. AMBULATORY OUTPATIENT MEDICAL (AOM) SERVICE DELIVERY BARRIERS:

A. Issues Relating to Ambulatory Outpatient Medical (AOM) Service Delivery as Reported by Providers:

- Mr. Vega-Matos provided a PowerPoint presentation on Update on the Implementation of Ambulatory Medical.

- DHSP funds 19 Community-Based Organizations and the Department of Health Services for AOM and MCC at 40 sites. There were 16,995 reported patients and 82,871 visits in FY 2011. Key health care landscape changes began in FY 2012.
- Migration to LIHP, Medicaid Expansion and ACA plus better eligibility tracking and reporting of other payer sources has led to continuing AOM utilization declines: FY 2012, 16,599 patients, 70,693 visits; FY 2013, 9,903 patients, 33,611 visits; FY 2014, 7,043 patients, 17,981 visits; estimated FY 2015, 4,036 to 6,055 patients, 24,221 visits.
- PP&A had requested provider feedback on any issues they were encountering due to the changing health care landscape. Mr. Vega-Matos provided feedback from the Medical Advisory Committee.
- One issue pertains to feasibility of some performance measures if a provider's patient mix now includes more Medi-Cal than Ryan White patients. Current measures were developed prior to significant patient migration to other payer sources. Each measure has a benchmark and providers' rates are reset periodically based on their performance. Should any measures need to be revised, they will be referred to SBP.
- Providers also noted issues with navigating changing payer sources, e.g., clients moving back and forth between payer sources. They also noted that time required to screen patient for services such as Benefits Specialty has increased.
- ➲ DHSP staff will send Update on the Implementation of Ambulatory Medical PowerPoint to Commission staff for PP&A distribution.

10. NEXT STEPS: There were no additional action items.

11. ANNOUNCEMENTS: There were no announcements.

12. ADJOURNMENT: The meeting adjourned at 3:40 pm.